



New Hampshire

Proton Pump Inhibitor

NH Medicaid Prior Authorization/Non-Preferred Drug Approval Form



First Health Services

Fax: 1-888-603-7696

Phone: 1-866-675-7755

Date of Medication Request: ____/____/____

SECTION I: Patient Information and Medication Requested

Name: (Last, First) _____

NH Medicaid Number: _____

Date of Birth: ____/____/____

Gender: ☐ Male ☐ Female

Drug Name: _____

Strength: _____

Dosing Directions: _____

Length of Therapy: _____

SECTION II: Clinical History

- Patient's Diagnosis: _____
- Have any recent GI procedures been performed? (check and complete all that apply)

| <u>Procedure:</u> | <u>Date of Procedure:</u> | <u>Findings:</u> |
|---|---------------------------|------------------|
| <input type="checkbox"/> Upper GI Series | ____/____/____ | _____ |
| <input type="checkbox"/> Barium Swallow | ____/____/____ | _____ |
| <input type="checkbox"/> Serum Gastrin | ____/____/____ | _____ |
| <input type="checkbox"/> Endoscopy | ____/____/____ | _____ |
| <input type="checkbox"/> Serum Secretion Stimulation Test | ____/____/____ | _____ |
- Has patient had a failure (4 week trial) on an acute dose of an H2 Receptor Antagonist in the past two years? ☐ Yes ☐ No
If yes, name medication: _____ Date of trial: ____/____/____
- Is the patient H. Pylori positive? ☐ Yes ☐ No Date: ____/____/____
- Recurrent GERD symptoms on acute dose of H2 blockers or PPI > 4 weeks? ☐ Yes ☐ No
If Yes, which one? _____
- Is there any additional information that would help in the decision-making process? If additional space is needed, please use another page.

If you are requesting a non-preferred product, proceed to Section III. If not, then proceed to Section IV.**SECTION III: Non-Preferred Drug Approval Criteria**

Chapter 188 of the Laws of 2004 requires that Medicaid only cover non-preferred drugs upon a finding of medical necessity by the prescribing physician. Chapter 188 requires that you base your determination of medical necessity on the following criteria.

- ☐ Allergic reaction ☐ Drug-to-drug interaction. Please describe reaction: _____
- ☐ Previous episode of an unacceptable side effect or therapeutic failure. Please provide clinical information: _____
- ☐ Clinical contraindication, co-morbidity, or unique patient circumstance as a contraindication to a preferred drug. Please provide clinical information: _____
- ☐ Age specific indications. Please provide patient age and explain: _____
- ☐ Unique clinical indication supported by FDA approval or peer reviewed literature. Please explain and provide a reference: _____
- ☐ Unacceptable clinical risk associated with therapeutic change. Please explain: _____

SECTION IV: Prescriber Information

Name: _____

DEA Number: _____

Phone #: (____) _____ - _____

Fax #: (____) _____ - _____

I certify that the information provided is accurate and complete to the best of my knowledge and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability._____
Signature of Prescribing Provider